CON Task Force Issue Brief

Capital Expenditure Threshold

Statement of the Issue

Should the capital expenditure threshold be increased?

Summary of Public Comments

Adventist HealthCare recommended that MHCC increase the capital expenditure threshold to $10 million. According to Adventist HealthCare, the continually rising cost of health care services makes the current $1.6 million threshold outdated. Increasing the threshold to $10 million would allow MHCC to focus its resources on major projects rather than smaller projects with less impact.

CareFirst supports an increase in the threshold for review. According to CareFirst, the appropriate threshold for hospital renovation projects is in the range of $5.0-$10.0 million. It is not clear that an inflator need to apply given the large increase from $1.6 million. Further, CareFirst notes that the operating cost associated with $10 million in capital cost is a tiny portion of a hospital budget and, without a CON, should not lead to higher payment rates. CareFirst did not take a position on the appropriate threshold for other services, other than to note that there is no reason why the threshold need be the same for other types of projects.

Carroll Hospital Center supports raising the capital expenditure threshold to $7.5 million as recommended by the Maryland Hospital Association. According to Carroll Hospital Center, as many hospitals find their facilities aging, increasing the capital expenditure would reduce the number of projects that the MHCC needs to review that mainly involve renovation to existing space.

Civista Medical Center recommended raising the capital threshold to at least $5.0 million, adjusted annually for inflation to better reflect the increasing cost of capital improvement projects, as well as the increasing need for physical plant upgrades.

Comments submitted on behalf of the **Health Facilities Association of Maryland** stated that the capital threshold is far too low. According to HFAM, roof and window repairs, HVAC upgrades and similar costs can easily exceed the threshold for capital expenditures. These are necessary expenditures that sometimes cannot be planned long in advance. There are stricter requirements for fire safety that need to be met. HFAM states that increasing the threshold will enable facilities to maintain physical plant in keeping with current standards.

Public forum comments from **LifeSpan** supported the Maryland Hospital Association's recommendation to raise the capital threshold to $7.5 million.

The Maryland Hospital Association (MHA) stated that the capital threshold should be raised to at least $7.5 million, adjusted annually for inflation, to better reflect the increasing costs of capital improvement projects, as well as the increasing need for physical plant upgrades.

MedStar Health suggested that consideration be given to increasing the dollar threshold to $7.5 million or higher to reduce the number of reviews and focus on projects with greater health system impact.

Barry Rosen, Esq. indicated that the $1.6 million threshold is too low. He recommended a more flexible approach with a threshold that is equal to a percentage of a facility's annual revenue (i.e., $10 million is a lot of money for some facilities, but not a lot of money for others).

Suburban Hospital commented that the capital expenditure threshold for CON exemption should be raised to $7.5 million, with annual adjustments for inflation.

The **University of Maryland Medical System** recommended that the capital threshold for CON review be increased from $1.65 million to $10 million to allow hospital providers to meet patient demand, implement patient safety programs in a more efficient manner and also to save the State's resources.

Background

Under Maryland health planning law, a CON is required before a new health care facility is built, developed, or established; an existing health care facility is moved to another site, subject to some limitations; the bed capacity is changed, subject to several limitations; the type or scope of any health care service offered by a health care facility is changed. In addition, any health care facility that makes a capital expenditure that exceeds the threshold for capital expenditures is required to obtain a CON. The current capital expenditure review threshold is $1,650.000.[1]

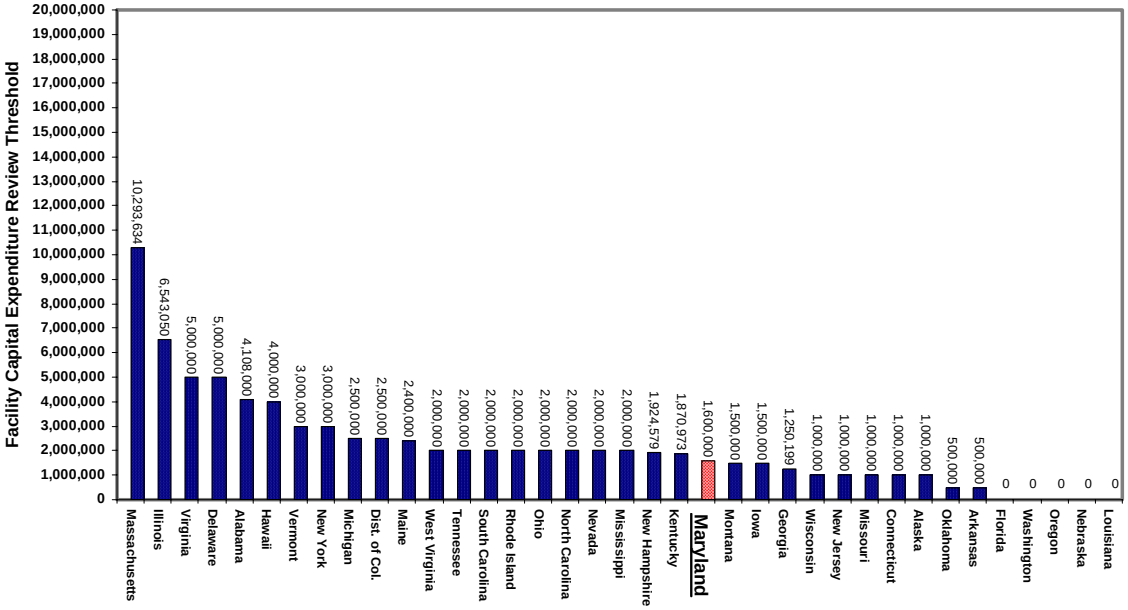
The capital expenditure threshold functions as a trigger for CON review in conjunction with the other requirements of the law. For example, if an action would otherwise require a CON, then that requirement would apply regardless of whether the capital expenditure was below the review threshold. In the case of acute care hospitals, the capital expenditure threshold functions as a trigger in conjunction with provisions in the statute that give hospitals the ability to undertake certain types of projects above the threshold without the requirement for a CON, provided the project does not require, over the entire period or schedule of debt service associated with the project, a total cumulative increase in patient charges or hospital rates of more than $1,500,000 for the capital costs. The ability to avoid CON review for over-threshold capital expenditures by "taking the pledge" not to increase rates applies only to hospitals.

Because of differences in the scope of CON programs nationally, comparative data on capital expenditure thresholds is limited. Based on available data from the American Health Planning Association, Maryland's health facility capital expenditure review thresholds have generally been near

[1] The former Health Resources Planning Commission's original enabling statute (Ch. 108, Acts of 1982) set the capital review threshold at $600,000; this was amended in 1988 (Chs. 688 and 767, Acts of 1988) to $1,250,000. Beginning in 1995, the capital expenditure threshold was indexed annually to consider inflation. In a revision to CON procedural regulations effective November 6, 1995, the definition of "threshold for capital expenditures" was expanded to add the phrase "for 1995, after that to be adjusted annually by the Commission according to the Consumer Price Index-Urban (CPI-U) for the Baltimore Metropolitan Area published by the U.S. Department of Labor, and rounded off to the nearest $50,000."

the national norm over the last decade. In 1993, the Maryland threshold ($1.25 million) was substantially higher than the national median and mode, both $1.0 million. In 1996, the Maryland threshold was roughly equal to the national median and still higher than the mode. Maryland is one of six states with CON programs that index their capital expenditure thresholds.[2] By 2004, the Maryland threshold ($1.6 million), though indexed, was lower than both the national median ($2.0) and mode ($2.0 million) threshold values in comparable CON states.

State Certficate of Need Program
Facility Capital Expenditure Review Thresholds
2004



Source: American Health Planning Association, 2005

Issues and Options

The Task Force received comments from 11 organizations supporting an increase in the capital expenditure threshold for CON review. The comments recommended an increase in the capital expenditure threshold ranging from $5.0 to $10.0 million. There was also a recommendation to base the threshold on a percentage of revenue rather than have a fixed dollar threshold. In suggesting that the capital expenditure threshold be increased, most commenters believed that this would decrease the number of projects requiring CON review.

[2]Except for Maryland, which does not regulate major medical equipment, states that index their health facility capital expenditure review thresholds also index their medical equipment review thresholds.

Table 1 profiles the last ten and a half years of CON project review activity and determinations on non-coverage (i.e., determinations that capital projects did not require CON approval) by size of capital expenditure. As this table indicates, only 11 of 203 projects reviewed (5.4%) required CON review solely because they involved capital expenditures that exceeded the expenditure threshold for review. Conversely, 117 hospital projects involving capital expenditures exceeding the review threshold were allowed to proceed without CON review because the sponsoring hospitals "took the pledge." Of the 11 projects, six were from acute care hospitals, one was from a psychiatric hospital, and four were from nursing homes. Four of the six acute care hospital projects were large capital renovation projects. The psychiatric hospital project was a facility replacement and renovation project. The four nursing home projects involved physical plant renovation and replacement.

Table 1
Certificate of Need Projects and Determinations of Non-Coverage by Capital Expenditure: Maryland, 1995-2005 (January-May 2005)

Capital Expenditure (in millions)	All CON Projects	CON Projects-Capital Expenditure Threshold Only	All Determinations of Non-Coverage	Determinations of Non-Coverage-Hospital Pledge Projects
$45.0 and Over	8	2	4	4
$40.0-$44.9	1	0	0	0
$35.0-$39.9	0	0	0	0
$30.0-$34.9	3	1	3	3
$25.0-$29.9	3	3	1	1
$20.0-$24.9	2	0	1	1
$15.0-$19.9	0	0	5	4
$10.0-$14.9	8	2	10	10
$5.0-$9.9	12	2	26	25
$1.0-4.9	28	1	97	69
Under $1.0*	138	0	53	0
TOTAL	**203**	**11**	**200**	**117**

Source: Maryland Health Care Commission
(*includes a small number of projects with no cost or costs not stated)

The data suggests that raising the capital expenditure threshold used in Maryland's CON program to $5.0 - $10.0 million would have a small impact on the number of hospital projects requiring or not requiring CON review. Most of the smaller hospital capital projects do not seek CON review and take the "pledge" not to increase rates.

The options for increasing the capital threshold identified in the comments include: $5.0 million; $7.5 million; and $10.0 million. A related issue concerns whether there should be one capital threshold for all projects, as is now the case, or whether there should be separate thresholds for acute care hospital versus nursing home/other projects. Given the differences between capital projects undertaken by hospitals versus nursing homes, it could be argued that a higher threshold (e.g., $10.0 million) should be applied to hospitals. On the other hand, a single threshold have would some administrative advantages and $7.5 million seems to have support in comments received from both hospitals and nursing homes.

Another issue concerns whether the threshold should continue to be indexed annually for inflation.